Binning Insurance

608-234-1521
PO Box 574, Deforest, WI 53532
binninginsurance@gmail.com

2024 Medicare Part D Questionnaire

(Annual Enrollment Period 10/15/2023-12/07/2023)

Name: _____ DOB: _____

Spouse's Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____

City: _____ County: _____ Zip: _____

My current PRESCRIPTON DRUG plan is: _____

My current monthly premium for my DRUG PLAN is: $_____

Spouse's DRUG plan (If applicable): _____

Spouse's Monthly PRESCRIPTION DRUG PLAN premium is: $_____

Medication	Dosage (tab or cap)*	Quantity Per Day

* If not specified we will use tablets.

(If you are on Inhalers, Ointments and Creams please list on your sheet how often you fill EACH of them. If you take Insulin please note how many pens per month)

Please list 2-3 preferred pharmacies you WILL go to _____

_____

Please send me information of Dental Insurance: YES NO

My current Dentist is:

Name: _____

Address: _____

As always, your referrals are very much appreciated. If you know of someone who might benefit from ANY of our services, please complete the following information:

Name: _____

Phone: _____ Email: _____

Address: _____

City: _____

Please send to:
Binning Insurance
P.O. Box 574
Deforest, WI 53532

Or Email
binninginsurance@gmail.com

Questions?
Call Binning Insurance at 608-234-1521.

Thank you for choosing Binning Insurance!